Diabetes Self-Management Education Referral Form

Patient's Name _____ **SSN:** _____**DOB:**_____ **Phone #:** _____ **Date:** _____

Diabetes Diagnosis: □ **Type 1** □ **Type 2 on insulin** □ **Type 2 Oral Agent** □ **Type 2, Diet Controlled** □ **GDM** □ **pre-existing diabetes with pregnancy**

Need for Diabetes Education
I certify that diabetes self-management education services are needed under a comprehensive plan for this patient's diabetes care: (*mark 1 or more of the following reasons for patient referral*)

□ New onset diabetes-date of diagnosis _____

□ A change in treatment regimen

- □ No diabetes medications to diabetes medication
- □ From oral diabetes medications to insulin

□ Inadequate glycemic control

- □ HbA1c≥ 8.5% on 2 or more consecutive HbA1c determinations 3 or more months apart before the patient begins the education process

  #1 HbA1c & date _____ #2HbA1c & date _____

- □ Documented acute episodes of severe hypoglycemia or acute hyperglycemia occurring in the past year during which the patient needed ER visits or hospitalization

□ High-risk for at least one of the following documented complications:

- □ Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputations
- □ Pre-proliferative or proliferative retinopathy or prior laser treatment of eye
- □ Kidney complications related to diabetes, when manifested by albumin, without other causes or elevated creatinine

Language spoken: □ English □ Other: _____

Please list all medications: _____

_____

_____

Health Insurance: _____

Management Plan of Care

The patient is to attend the following:

□ Comprehensive Management Skills Group Class
□ Management of Diabetes During Pregnancy
□ Nutrition Management (1:1)
□ Self Blood Glucose Monitoring (1:1)
□ Insulin Instruction (1:1)
□ Complications (Acute) Instructions (1:1)
□ Complications (Long-Term) Instructions (1:1)
□ Insulin Pump Start-up
□ Other: _____

Diabetes Lab Results

□ FBS _____mg/dl Date: _____
□ HbA1C _____ % Date: _____
□ Microalbumin _____ Date: _____
□ Cholesterol _____ mg/dl Date: _____
□ LDL _____ mg/dl Date: _____
□ BP _____Hg/mm Date: _____

Diabetes Complications

□ Retinopathy □ Nephropathy □ Hypertension
□ Neuropathy □ Depression □ Gastroparesis
□ CVD □ Hyperlipidemia □ Other: _____

Existing barriers that impede patient's ability to obtain diabetes self-management skills through group instructions

□ Visual/Hearing Impairment □ Impaired Mental Status
□ Learning Disability □ Impaired Psychosocial Status
□ Impaired Mobility □ Impaired Dexterity
□ Other _____

Provider's Signature:_____